



Chatting Children Speech and Language Center, LLC
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Child's Name: _____ Date of Birth: _____ Today's Date: _____

Address: _____

Phone: _____
(home) (work) (cell)

Mother's Name: _____ Father's Name: _____

Mother's Occupation: _____ Father's Occupation: _____

Mother's email address: _____ Father's email address: _____

Name, Phone, Email of Nanny/Caregiver: _____

Siblings (include names and ages): _____

Referred by: _____

Pediatrician: _____ Phone: _____

Pediatrician's Address: _____

List other professionals working with (or who have worked with) your child:

Names/Professions:

Phone Numbers:

Is your child currently being treated by another speech-language pathologist? If so, please provide their name, telephone number and email.

Does your child attend school, day-care or any other program? If so, please specify the name of program, days attended and length of day.

Medical History

How was the mother's general health during pregnancy (please explain)? _____

Were there any complications during labor and/or delivery (please explain)? _____

Was your child born premature? If so, please provide details as to difficulties and treatment.

Apgar scores: _____ Birth weight: _____

Was your child nursed and if so, for how long? _____

Was there anything remarkable about your child's early feeding history? _____

Has your child been given a medical diagnosis? ____ If yes, what diagnosis? _____

Has your child had any surgeries? ____ If yes, what type and when? _____

Has your child ever suffered from ear infections? ____ If yes, how many? ____ Which ears? _____
At what ages? _____ Were PE tubes inserted? _____ If yes, at what age? _____

Has your child's hearing been tested? ____ If yes, please indicate when, where and the results.

Is your child sensitive to certain sounds/pitches (e.g., vacuum cleaners, blenders)? _____

Does your child cover his/her ears when he/she hears certain sounds? (specify) _____

Does your child seem under-reactive to loud sounds (e.g., fire trucks)? _____

Is your child currently taking any medications? ____ If yes, please identify. _____

Does your child have any allergies? If yes, please identify. _____

Is your child on a special diet? If yes, please describe. _____

Have any family members been treated by a speech-language pathologist? ____ Please explain.

Have any family members been diagnosed with autism? _____

Developmental History

Please provide the approximate age at which your child began doing the following activities:

Crawl _____ Walk _____ Feed self _____ Use toilet _____

Use single words (e.g., mama, no, plane) _____

Combine words (e.g., daddy car, eat cookie) _____

Engage in conversation _____

What languages are spoken in the home or any of your child's other settings? _____

Do **you** understand your child when he/she communicates? _____

Do **others** understand your child when he/she communicates? _____

Is your child showing signs of frustration arising from his/her communication? _____

Does your child repeat sounds, syllables or words within an utterance (e.g., "b-b-b-ball")? _____

How often does your child repeat sounds, syllables or words? _____

Does your child make eye contact with others? _____

How does your child interact with other children and adults (e.g., shy, aggressive, uncooperative)?

Please explain your child's typical eating habits: _____

When eating, does your child prefer specific textures (e.g., mushy, crunchy), tastes (e.g., sour, sweet, salty), or temperatures (e.g., hot, cold)? _____

Does your child use an open cup? _____ Sippy cup? _____ Straws? _____

Does your child use a pacifier? _____ At what age did he/she stop? _____

Does your child suck his/her thumb? _____ At what age did he/she stop? _____

Does your child drool? _____

Can your child blow bubbles? _____ Party horns/whistles? _____

Describe your child's sleeping patterns. _____

Describe your child's activity level (low, typical, high). _____

Does your child exhibit any unusual behaviors or have unusual interests? If yes, please describe.

What activities does your child enjoy the most? _____

How does your child spend most of his/her time? _____

How much time does your child spend watching TV per day? _____

How is your child doing academically (or pre-academically)? _____

If enrolled for special education services, has an Individualized Education Plan (IEP) or other specialized plan been developed? If yes, what services are included? Please provide a copy of the IEP or plan.

Which of the following concerns do you have? (check all that apply)

_____ 1) your child's overall articulation (pronunciation of words)

_____ 2) your child's comprehension of language

_____ 3) your child's ability to use language to converse

_____ 4) your child's eating habits

_____ 5) your child's dysfluent speech (stuttering)

_____ 6) your child's ability to read

_____ 7) your child's phonological awareness skills (pre-reading skills such as rhyming, sound ID)

_____ 8) your child's auditory processing

_____ 9) your child's play/social skills

Who recommended that you see a speech-language pathologist? _____

Please provide any additional information that might be helpful in the evaluation or remediation of your child's speech and language problem.
